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The 2022 Palliative Medicine Curriculum

Housekeeping

Please can all attendees

- Turn camera off
- Mute microphones

- Write questions in the Chat: all questions will be taken at the end of the presentations

Overview

- Background to the new curriculum
- Capabilities in Practice
- Workplace based assessments and SLEs
- E-Portfolio
- Transition to the new curriculum
- Interface between specialty training and IM
- The trainee experience
- Question and answer session

The story so far…..

Timeline	Progress
2013 Shape of Training report	Recommended majority of specialties move to broad-based training to better meet changing population needs (ageing, frailty, multi-morbidity)
March 2017	UK Shape of Training Steering Group confirmed Palliative Medicine would be a "Group 1" specialty Dual accreditation from 2022 with Internal Medicine (IM)
January 2019	GMC Curriculum Oversight Group approved the first phase of the new curriculum submission, the "purpose statement' • Competitive entry at ST4 after IM3 • Dual accreditation with IM over 4 years
October 2019	New curriculum consultation – report submitted to JRCPTB and GMC Jan 2020 Parallel APM consultation/survey
January to March 2020	Equality impact assessment consultation led by RCP SAC response to consultation sent to JRCPTB and GMC
February 2020	GMC confirmed "The GMC and four nations are committed to Palliative Medicine being a group 1 specialty and the proposal is for the four nations to come back to the GMC with models for delivery"
2020-2021	All Deaneries working with RCP and local training leads to develop implementation plans
November 2021	GMC Curriculum Advisory Group approved new Palliative Medicine curriculum subject to enhanced monitoring
March 2022	GMC gave full approval to new curriculum – start date August 2022

The new training pathway

The physician training pathway

Foundation training (2 Years)

Selection

Internal Medicine Stage 1 training (3 years)

Mandatory items
- Acute medicine
- Acute take
- Outpatients
- Geriatric medicine
- ITU/HDU
- Simulation

Medical Registrar

Selection

Specialty training
(indicative 4 years)

Internal Medicine Stage 2 (in specialty)

Internal Medicine Stage 2 (acute care)

Specialist certification

MRCP(UK)

SCE/KBA

Workplace-based assessment

The main changes to the curriculum

- 4-year programme including IM
- Enhanced recognition of changing need: Frailty, multi-comorbidity, ageing population, organ failure, supportive care in cancer, transition services
- Indicative recommendation: minimum 6-months in all settings (community, hospital and specialist inpatient)
- More detail around what we are expecting from trainees to meet capabilities, e.g.
  - Involvement in specialty take/ on call
  - Working in different settings: hospice/ specialist inpatient, community and hospital advisory palliative care
- Public health palliative care
- Looking to the future, e.g. technology
- Self care and resilience

Public Health in the new curriculum

- Shift from a narrow, biomedical model of Public Health to develop understanding contemporary themes and health promotion, supported by experts in the field
  - Ensuring descriptors supporting Palliative Medicine CiPs reflect up to date practice, e.g.
    - Awareness of the impact of life-limiting illness on social participation and support networks
    - Awareness of positive and negative impacts of caring on those close to patients with life-limiting illness (CiP 6)
    - Awareness of and ability to work alongside community and social resources to support vulnerable people (CiP 6)
    - Awareness of dying as a social process (CiP 5)
  - Section in syllabus to outline context for focus on public health in palliative care, community empowerment and health promotion to improve outcomes at the end of life
- Development of training programme to support curriculum implementation
  - Four webinars, a study day and group workshop on compassionate community sills in the clinical setting

What has not changed

- Training across all palliative care settings
- Broad approach to training, e.g.
  - Holistic palliative care approach, underpinned by evidence and clinical practice
  - Palliative care approach based on need not diagnosis
  - Underpinning knowledge and skills, e.g. detailed assessment, pharmacology, communication
- Flexibility to meet individual trainee needs
- Assessments to support learning
  - Supervised learning events, e.g. mini-CEX, CbD, RRP
  - DOPS
- SCE (Palliative Medicine only)

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Capabilities in Practice (CiPs)

Capabilities in practice

- Capabilities in practice (CiPs) describe the professional tasks or work within the scope of a curriculum
- CiPs are based on the format of entrustable professional activities
- They utilise professional judgement of appropriately trained, expert assessors (clinical and educational supervisors)
- They provide a defensible way of forming global judgements of professional performance
- In order to complete training the doctor must demonstrate that they are capable of unsupervised practice in all CiPs as detailed in the curriculum

Capabilities in practice

Each CiP is further broken down into:

- descriptors
- the expected levels of performance
- how the CiP is mapped to the relevant Generic Professional Capabilities (GPC)
- the evidence that may be used to inform entrustment decisions

5. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings	
Descriptors	• Ability to recognise (and support other clinicians to recognise) dying, including an understanding of clinical uncertainty and limited reversibility in people with progressive life-limiting conditions • Safe implementation of anticipatory care for patients who are approaching the last days of life, including prescribing, advance care planning, escalation plans and establishing priorities for care • Ability to proactively support other professionals in developing effective management strategies and plans for caring for dying patients • Ability to coordinate palliative care and support teams caring for those with specific needs such as learning disability or complex mental health needs • Safe and effective use of medication in the dying phase to manage common and complex symptoms • Ability to judge the appropriateness of interventions in dying patients • Awareness of the role environment plays in caring for the dying patient and ability to adapt accordingly e.g. hospital, own home, hospice/inpatient unit, care home or other community setting/place of residence or secure settings such as prison • Ability to identify and manage distress at the end of life in patients (and those close to them) and colleagues • Demonstrates detailed understanding and application of the ethical and legal frameworks and legislation supporting decision making at the end of life, including mental capacity legislation and the national medical examiner scheme (England and Wales) • Development of expert skills in ethical reasoning and decision-making in end-of-life care • Awareness of dying as a social process; appreciates and facilitates the role of a wider social network and non-professional support at this time and understands the positive impacts of health-promotion and community engagement in end of life care

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills • Dealing with complexity and uncertainty Domain 3: Professional knowledge Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training

Evidence to inform decision	SCE CbD mini-CEX Reflective practice MCR LEADER ES report Review of clinical activity patient log, e.g. community experience

Capabilities in practice descriptors

- Each CiP has a set of descriptors associated with that activity or task
- These descriptors indicate the minimum level of knowledge, skills and attitudes which should be demonstrated
- The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance

Capabilities in practice

The CiPs are grouped into three categories

Generic CiPs	Internal Medicine Clinical CiPs	Specialty CiPs
Covering the universal requirements of all specialties as described in Good Medical Practice (GMP) and Generic Professional Capabilities (GPC) frameworks	Covering the clinical tasks or activities which are essential to the practice of internal medicine	Covering the clinical tasks or activities which are essential to the practice of that particular specialty

The nine domains of the GMC's Generic Professional Capabilities

Generic CiPs

1. Able to successfully function within NHS organisational and management systems
2. Able to deal with ethical and legal issues related to clinical practice
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focussed on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately
6. Acting as a clinical teacher and clinical supervisor

Internal Medicine Clinical CiPs

1. Managing an acute unselected take
2. Managing the acute care of patients within a medical specialty service
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long term conditions)
5. Managing problems in patients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing acutely deteriorating patients
8. Managing end of life and applying palliative care skills

Palliative Medicine Specialty CiPs

1. Managing patients with life limiting conditions across all care settings
2. Ability to manage complex pain in people with life limiting conditions across all care settings
3. Demonstrates the ability to manage complex symptoms secondary to life limiting conditions across all care settings
4. Ability to demonstrate effective advanced communication skills with patients with life limiting conditions, those close to them and colleagues across all care settings
5. Ability to manage, lead and provide optimal care of the complex dying patient and those close to them across all care settings
6. Manage delivery of holistic psychosocial care of patients and those close to them including loss and grief; and religious, cultural and spiritual care across all care settings
7. Demonstrates the ability to lead a palliative care service in any setting, including the third sector

Example of a Palliative Medicine CiP

CiP 2. Ability to manage complex pain in people with life limiting conditions across all care settings	
Descriptors	•Up-to-date knowledge, understanding and skills to assess and manage complex pain secondary to life-limiting progressive disease, taking into account patient preferences and reversibility • Knowledge of the pathophysiology of pain to inform pain assessment and management • Application of evidence-based knowledge and skill in the effective use of non-pharmacological management, opioid & non-opioid analgesics to manage complex pain, including safe prescribing in patients with organ failure, frailty and low body weight or who are in the last hours or days of life • Knowledge of managing pain whilst minimising longer term adverse effects in those with progressive disease but longer prognoses • Appropriate knowledge of interventional pain techniques to effectively manage complex pain that is not responding to conventional treatments • Ability to refer to and share care with other pain services • Ability to safely manage pain in the context of drug misuse and dependence

CiP 2. Ability to manage complex pain in people with life limiting conditions across all care settings	
Generic Professional Capability Framework (GPC) domain links	**Domain 1:** Professional values and behaviours **Domain 2:** Professional skills • Practical skills • Communication and interpersonal skills • Clinical skills **Domain 3:** Professional knowledge **Domain 5:** Capabilities in leadership and team working **Domain 6:** Capabilities in patient safety and quality improvement **Domain 9:** Capabilities in research and scholarship
Evidence to inform decision	SCE CbD mini-CEX DOPs Reflective practice MCR ES report Review of clinical activity, e.g. community and interventional pain experience

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Workplace Based Assessments(WPBA) and Supervised Learning Events (SLEs)

New Workplace Based Assessments (WPBA) and Supervised Learning Events (SLEs)

- A range of WPBA can be used to inform sign off decisions about trainees experience
- Assessors make accountable professional judgements
- Professional judgements are used and collated to make holistic decisions on progression
- Do not need a specific number of WPBA per CiP – can be based on observation as well

Types of WPBA/ SLEs

Workplace-based assessment (WPBA)

- Direct Observation of Procedural Skills (DOPS) – summative

Formative assessment

Supervised Learning Events (SLEs)

- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Clinical Leadership Development (LEADER)

WPBA

- Direct Observation of Procedural Skills (DOPS) – formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

Palliative Medicine Minimum numbers of WPBA/SLEs

	ST4	ST5	ST6	ST7
MCR	2	2	2	2
MSF	1	1	1	1
ACAT	2	2	2	2
CbD or mini CEX	6	4	4	2
Patient survey	Complete one survey by end of training			
QIPAT		1		1 as supervisor
LEADER		1		1
RRP	2	2	2	2
Teaching observation	1	1	1	1

DOPS

Practical procedures – minimum requirements	ST4	ST5	ST6	ST7
Total Requirement	Minimum 1	Minimum 1	Minimum 1	Minimum 1 Evidence of completion of all mandatory DOPS (minimum total 7 by end of training)
Syringe pump set up	Skills lab or satisfactory supervised practice	Limited supervision	Limited supervision	Competent to set up independently (summative DOPS)
NIV set up and troubleshooting, e.g. checking the machine is set up according to the initiating team's advice, ensuring correct mask position and patient comfort, and be able to assess common problems/potential emergencies and know who to contact for advice	Skills lab or satisfactory supervised practice			Competent in simulated setting (summative DOPS)
Spinal lines: principles, indications and likely complications in relation to spinal lines e.g. how to recognise a problem, what to inspect and who to call for advice	Skills lab or satisfactory supervised practice			Competent in simulated setting (summative DOPS)
Tracheostomy care: management of common complications, e.g. secretions and a simple tube / tracheostomy change	Skills lab or satisfactory supervised practice			Competent in simulated setting (summative DOPS)
Indwelling pleural/peritoneal catheter: identification of appropriate patients; day to day management and troubleshooting of complications, e.g. displacement, infection, blockage	Skills lab or satisfactory supervised practice	Limited supervision	Limited supervision	Competent to manage complications and advise patients re:

DRAFT

Total 3 syringe pump DOPS during training to demonstrate maintaining competence

Min 1 of each of other DOPS

Simulation

- DOPS done as simulation – will need to develop and deliver Simulation programmes in regional hubs
- Pilot for DOPS has been done in London as a formative development day –
  - Excellent feedback
  - Will need to be scaled up
  - Funding from HEE
  - Consider SIM lead on STC
- May develop simulation for human factors and communication in the future

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ePortfolio

Eportfolio

- For those transitioning to the new palliative medicine curriculum, their old ePortfolio will not transfer to the new one (they will run alongside and need to be remapped)
- Trainees will have 2 curricula – IMT and palliative medicine (2022)
- Curriculum will be mapped to CiPs
  - Trainees will self rate each area and link items to justify their rating for each CiP.
  - Educational supervisor reviews trainees self rating, MCR and range of evidence for each CiP to then provide rating

New 2022 curricula – specialty specific changes

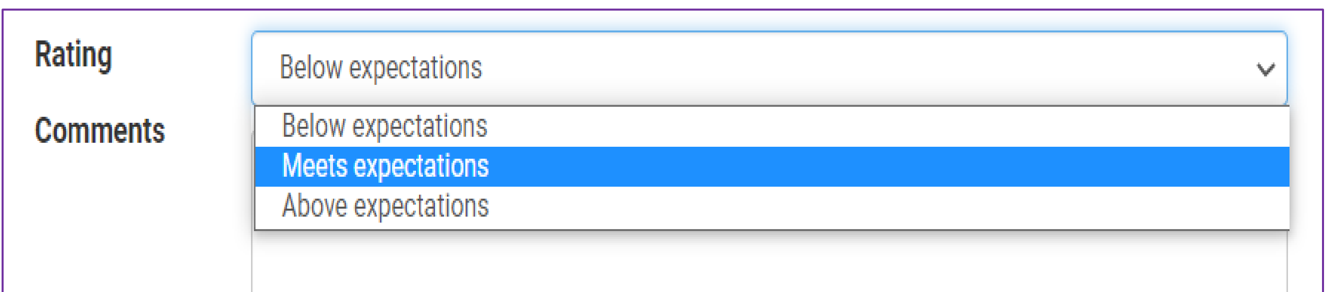
The new curricula are CiPs based and the CiPs will be grouped and appear on the curriculum page of the ePortfolio

Physician Geriatric Medicine & Internal Medicine 2022 Capabilities in Practice (CiPs)

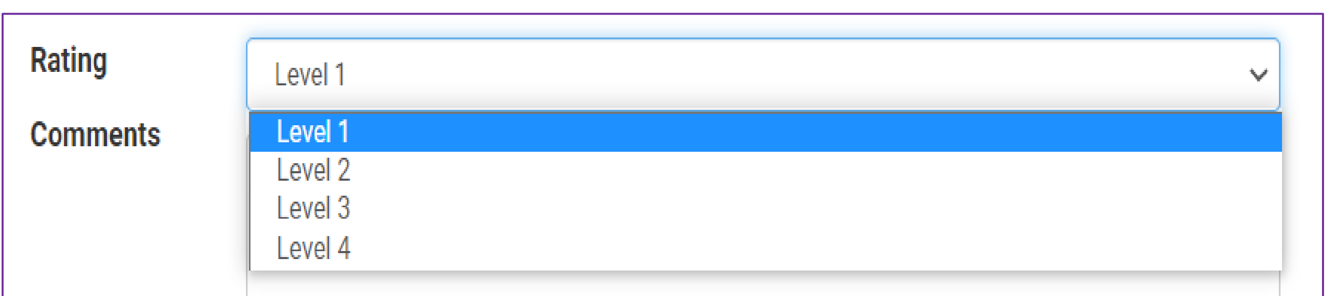
Geriatric Medicine & Internal Medicine (EMD660) – 04/08/2022 – 31/07/2027

- Generic Capabilities in Practice (CiPs)
- Internal Medicine Clinical Capabilities in Practice (CiPs)
- Specialty Capabilities in Practice (CiPs) - Geriatric Medicine
- Geriatric Medicine Specialty CiPs (themed for service)
- Practical Procedures

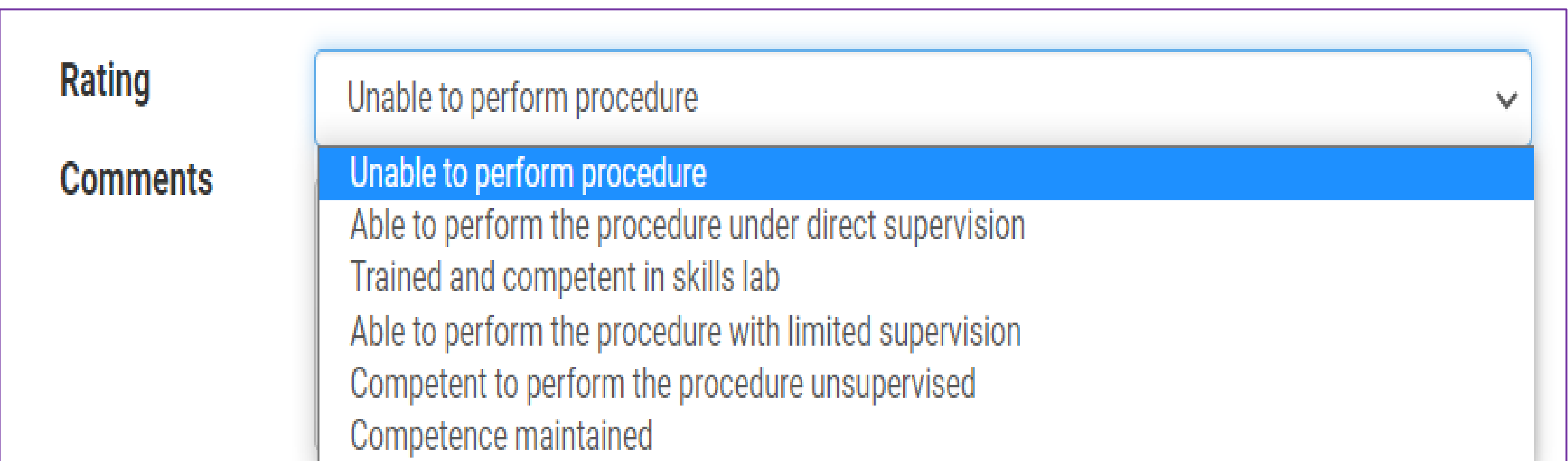
- Ratings for the generic CiPs:



- Ratings for Internal Medicine clinical CiPs and specialty CiPs:



- Ratings for practical procedures:



Multiple Consultant Report (MCR)

- This form is designed to help to capture the opinions of consultants who have supervised the trainee in clinical settings
- Respondents should provide feedback on the trainee's progress against the CiPs using global anchor statements
- It may not be possible to provide feedback against every CiP, however it is the trainees responsibility to ensure they have adequate feedback across the training year
- MCRs will be collated and summarised in the MCR Year Summary Sheet

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Example of an MCR which will be specific to each specialty curriculum

Multiple Consultant Report – Geriatric Medicine

1. Able to function successfully within NHS organisational and management systems

- ○ Below expectations for this year of training
- ○ Meeting expectations for this year of training
- ○ Above expectations for this year of training
- ○ Not observed

Please provide comments to justify your rating and identify any areas of concern or excellence.

Internal Medicine CiPs

Clinical Supervisors will record their rating for each CiP – they should only record feedback for the CiPs they have observed

1. Managing an acute unselected take

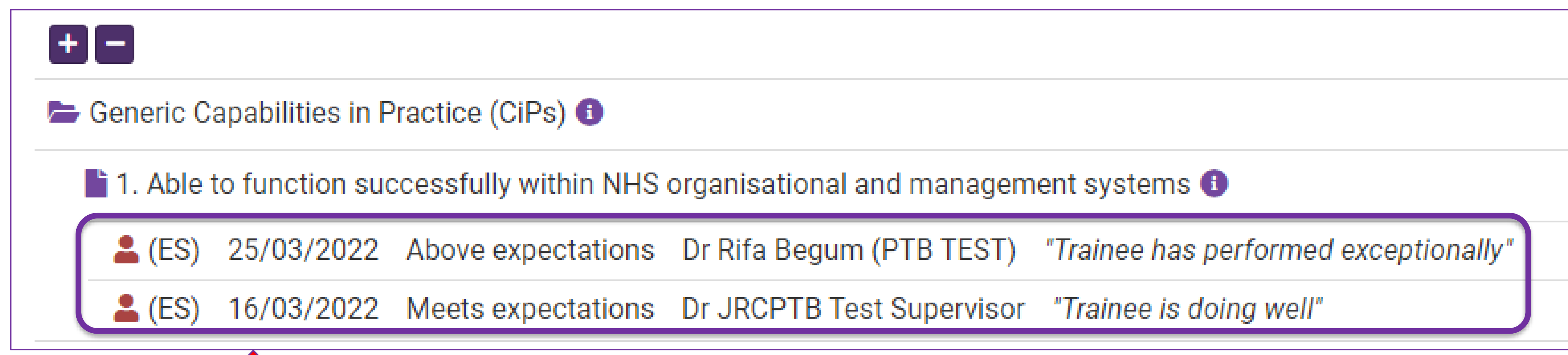
- ○ Below expectations for this year of training
- ○ Meeting expectations for this year of training
- ○ Above expectations for this year of training
- ○ Not observed

New Educational Supervisor’s Report

- Designed for each specialty . There will be a separate ES report for Internal Medicine
- The report will auto-populate the latest ratings and comments made by the Educational Supervisor taken from the curriculum page
- Educational Supervisors must ensure that they update the curriculum with the latest rating and comment for the CiPs prior to creating the report

New Educational Supervisor's Report – how the auto-population will work

Educational Supervisor rates and comments on the trainee's progression on the curriculum page. The ES generates the ES report which will pull through the latest ratings and comments from the curriculum page



Here two ratings have been made by the ES. The system will check the latest rating that was made and this will then be populated in the ESR

Educational Supervisor Report - example

Educational Supervisor's Report – Geriatric Medicine

Generic CiPs

1. Able to function successfully within NHS organisational and management systems

- Below expectations
- Meets expectations
- **Above expectations**

Comment: Trainee has performed exceptionally

When the ESR form is created, the CiPs ratings and comments will auto-populate.

The form can be saved as draft if the ratings or comment need to be updated before completing the report.

If the ESR form is saved in draft, it will update any changes made to the curriculum ratings and comments until it is saved as final

Internal Medicine CiPs

1. Managing an acute unselected take

- Level 1
- Level 2
- **Level 3**
- Level 4

Comment: 3 MCRs have been completed by consultants who have supervised the trainee in the acute setting and 2 of these are satisfied that she can manage the acute take with indirect supervision. The third was completed early in the training year

New Summary of Progression page

- Designed for each specialty to provide an overview of evidence recorded in the ePortfolio
- Organised in sections that reflect the ARCP decision aid
- It will auto-populate and display the latest data
- To be used for meetings between ES and trainees and for ARCP

The summary of evidence section will auto-populate with total number of assessment forms that has been completed within the date range for the year of training. The requirements for each specialty will be detailed in the ARCP decision aid.

Summary of evidence on the ePortfolio

Supervised Learning Events (SLEs)

Mini-CEX

CbD

Outpatient Care Assessment Tool (OPCAT)

Overall comments

Direct Observation of Procedural Skills (DOPS)

DOPS - total

Overall comments

Grade: IMY2

1. Educational supervisor (ES) report

One per year to cover the training year since last ARCP (up to the date of the current ARCP)

Requirement:
Confirms will meet the critical progression point and can progress to IMY3 and act as medical registrar

Evidence:

Educational Supervisors Report (IMT) 13 Jun 2019 Miss Rifa Begum (PTB TEST) (Meets expectations for this year of training) View

2. Generic capabilities in practice (CiPs)

Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings. Trainees should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP

Requirement:
ES to confirm trainee meets expectations for level of training

Evidence:

Above expectations

Meets expectations

Below expectations 2

Each section will auto-populate data if evidence has been recorded in the ePortfolio. Where there is specific indicative target, green will indicate that this has been met

3. Clinical capabilities in practice (CiPs)

See grid below of levels expected for each year of training. Trainees must complete self-rating to facilitate discussion with ES. ES report will confirm entrustment level for each individual CiP and overall global rating of progression

Requirement:
ES to confirm expected levels achieved for critical progression point at end of IMY2

Evidence:

Clinical CIP	Target (IMY2)	Evidence
1. Managing an acute unselected take	Level 3	Level 3
2. Managing an acute specialty–related take	Level 2	Level 1

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Transition of current trainees

Transition to New Palliative Medicine Curriculum

- **Optional transition**
  - Those who started training prior to August 2021 are encouraged to transition unless in their final year but are not required to do so.
  - If staying on 2010 curriculum, needs confirmation of this in their portfolio by TPD, preferably as part of the ARCP process.
- **Mandatory transition**
  - StRs starting training after August 2021 and those appointed from August 2021, unless :
    - GP or other non-CMT background
    - Exceptional personal circumstances
    - Patient safety concerns if they were to transition, e.g. length of time from CMT
  - Application can only be approved by Postgraduate Dean

Transition Process

- What needs to be done or has already been done?
  - Gap analysis
  - IM catch up training if needed – IMT3/ specialty training and IM stage 2
  - ES role – evidence on old and new curriculum
  - CCT date may change (agreed at ARCP)

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The interface between IM and Specialty Training

A broad range of Specialist Settings + IM stage 2 experience in acute Trusts – 2 examples of block approach

IMT 1-3 Entry into dual training after completing Stage 1 IM training

ST4 1 year Palliative Medicine - Inpatient hospice setting

ST5 4 months Stage 2 IM training (acute Trust) + 8 months hospital or community focused Palliative Medicine Training

ST6 4 months Stage 2 IM training (acute Trust) + 8 months hospital or community focused Palliative Medicine Training

ST7 4 months Stage 2 IM training (acute Trust) + 8 months Palliative Medicine - inpatient hospice setting

IMT 1-3 Entry into dual training after completing Stage 1 IM training

ST4 1 year Palliative Medicine - Inpatient hospice setting

ST5 6 months Stage 2 IM training (acute Trust) + 6 months hospital Palliative Medicine Training

ST6 12 months Community & Senior hospice Palliative Medicine Training

ST7 6 months Stage 2 IM training (acute Trust) + 6 months hospice or hospital Palliative Medicine

Principles of dual training

- IM training posts should provide trainees with perspectives on patient management delivered in other medical specialities
- Generic and IM capabilities can be acquired during specialty training AND placements labelled as internal medicine
    - Up to 3 months Palliative Medicine training can ‘count’ towards acquisition of IM capabilities

Implementation of training – dual training during specialty training (hospice/hospital)

- IM CiP5: Managing medical problems in patients in other specialties and special cases

Implementation of training – dual training during specialty training (hospice/hospital/community)

- IM CiP5: Managing medical problems in patients in other specialties and special cases
  - Our trainees will demonstrate effective consultation skills including in challenging circumstances
  - They will manage medical problems for inpatients under the care of other specialties
  - They will demonstrate appropriate and timely liaison with other medical specialty services when required

Implementation of training – dual training during specialty training (hospice/hospital/community)

- IM CiP6: Managing a multi-disciplinary team including effective discharge planning

Implementation of training – dual training during specialty training (hospice/hospital/community)

- IM CiP6: Managing a multi-disciplinary team including effective discharge planning
  - Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover
  - Effectively estimates length of stay & identifies appropriate discharge plan
  - Delivers patient-centred care including shared decision making
  - Recognises the importance of prompt and accurate information sharing with primary care team following hospital *(or specialist palliative care unit)* discharge

Principles of dual training

- Separate Educational Supervision and GIM representation at ARCP are the gold standard. Eventually we will produce trainers comfortable with supervision of both IM and specialty curricula

- TPDs will work with training units and trainees to facilitate 'Keeping in Touch' training (Palliative Medicine whilst in IM, IM whilst in Palliative Medicine), e.g.
  - Specialty and IM training days
  - Procedural skills simulation
  - Acute take, AMU and SDEC sessions
  - Outpatient and community experience outside of Palliative Medicine

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The trainee experience

Emily

Route into ST3 palliative medicine –

'CT3 year' – 6 months acute/elderly registrar then 6 months community geriatrics then St Gemma's specialty doctor for 6 months then entry to ST3 Feb 21

Curriculum gap after analysis – critical care experience

Closing the gap – 10 week placement in ICU

Kathryn

Route into ST3 palliative medicine – Core Medical Training

Curriculum gap after analysis – Intensive care medicine

Closing the gap – 4 Month ICM placement with Acute Medicine on calls

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Rose

Route into ST3 palliative medicine – CMT1-2, then clinical fellow in Palliative Medicine (hospice/ hospital), then ST3

Curriculum gap after analysis – further experience as a registrar on unselected acute take

Closing the gap – in ST3, spending every 5th week on AMU as medical registrar (total 6 weeks)

Stephanie

Route into ST3 palliative medicine - Acute Care Common Stem straight into ST3

Also an Academic Clinical Fellow in palliative medicine

Curriculum gap after analysis – working as medical registrar managing the acute take

Closing the gap – 3 month placement on medical registrar rota

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Final Thoughts

Final thoughts

- Major curriculum change from August 2022
  - Dual training
  - Change from competence assessment to CiPs
  - Matrix concept of generic, IM and Palliative Medicine CiPs, underpinned by GPC framework
- 2010 and 2022 curricula will run in parallel for some years
- Impact will be monitored via surveys to training units and trainees
- Early escalation of issues to TPDs important

GOOD LUCK!!!!